CHAPTER 2: CLINICAL CRITERIA

OBJECTIVE

This chapter provides participants with an overview of the clinical criteria and issues related to the Prospective Payment System for Medicare payment of swing bed (SB) skilled nursing services provided by a hospital. Participants will learn about the Medicare-related uses of the Minimum Data Set for swing beds (SB-MDS), required assessments, making a level of care decision, and the presumption of coverage.

OVERVIEW

Swing bed PPS Final Rule
- Effective service dates on and after 7/01/02

This chapter reflects the major clinical components of the PPS and the changes that have occurred to the e*xisting administrative criteria and to the determination of a covered level of care*. The changes began with the implementation of the SNF PPS Final Rule of Fiscal Year (FY) 1998. Please refer to the SNF PPS Final Rules from FY 1998 to present for an in-depth discussion of these changes.

The FY 2002 Final Rule (FR) for Swing Bed PPS is effective with cost reporting periods beginning on or after July 1, 2002.

Eligibility Criteria

Technical Eligibility Criteria
- Remains the same

Post-hospital extended care services furnished by a swing bed hospital must meet the established Medicare Part A eligibility requirements.

Technical Eligibility Requirements

Technical eligibility remains the same, as outlined below, per the Medicare Intermediary Manual, Claims Process, Part 3 (HCFA Pub. 13-3) and the Skilled Nursing Facility Manual (HCFA Pub. 12). The patient must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use

- There has been three-day qualifying stay prior hospital stay

- There has been thirty-day transfer (Receipt of extended care services in the swing bed hospital within thirty days after:
    1. Discharge from an acute bed in the swing bed hospital
       Or
    2. Discharge from another hospital

(Exception in HCFA Pub 13-3 Section 3131.3B Medical Appropriateness Exception applies)

Clinical Eligibility Requirements

A beneficiary is eligible for swing bed post-hospital extended care if all the following requirements are met:

- Beneficiary has a need for and receives skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals

- As a practical matter, these skilled services can only be provided in a SNF/swing bed

- The services provided must be for a condition which:

  Was treated during the patient's qualifying stay, **or** arose while the patient was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

Physician Certification

Physician Certification
- Required at the time of admission
  and
- First Re-certification, no later than 14th day
- Subsequent Re-certifications at least every 30 days
- Has no bearing on certifications required for therapy plans of treatment

A physician, clinical nurse specialist, or nurse practitioner must certify and then re-certify every thirty days, where such services are furnished over a period of time, the need for extended care services in the swing bed hospital.

Certifications are required at the time of admission or as soon thereafter as is reasonable and practicable. (42 CFR 424.20)

- The **first re-certification** is required no later than the **14th** day

- **Subsequent re-certifications** are required at least **30 days** after the first re-certification

The initial certification is a prerequisite to admission. The initial certification:

- Certifies, per the existing context found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, **or**

- Validates that the resident's assignment to one of the upper RUG-III (Top 26) groups is correct through a statement indicating the assignment is correct

Re-certifications are used to document the continued need for skilled extended care services.

These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.

Spell of Illness
- No break in a spell of illness if the resident continues to meet the skilled care definition

Spell Of Illness

When a SNF or swing bed resident has exhausted Medicare Part A benefits and continues to meet the level of care definition, there is **no** break in the spell of illness.

THE BASIC COMPONENTS OF SNF PPS, THE MINIMUM DATA SET (MDS), AND THE RUG-III GROUPS APPILCABLE TO SWING BED FACILITIES

The Minimum Data Set For Swing Bed Hospitals (SB-MDS)

Components of PPS
- SB-MDS
- RUG-III Groups

Swing bed providers will assess the beneficiary's clinical condition by performing an assessment using the Minimum Data Set for Swing Beds (SB-MDS). The SB-MDS provides the basis for the RUG-III classifications.

A **"customized MDS"** for swing beds has been developed. This new 2-page SB-MDS utilizes a subset of the "full MDS" information currently in use by the SNF. In addition, the SB-MDS data items identify the corresponding field/item on the full MDS.

Care Planning Requirements

Minimum Data Set (SB-MDS)
- Customized for swing beds
- 2-page assessment
- Care Planning and Quality Indicators are NOT required

Swing bed hospitals must continue to comply with hospital care planning requirements. Swing bed providers **will not be required** to perform the care planning and quality monitoring components included in the resident assessment process required by the Omnibus Budget Reconciliation Act of 1987.

The customized SB-MDS will include only those items needed for payment and ongoing analysis of the characteristics and service utilization of swing bed patients. Detailed instructions for MDS completion are found in the *Long Term Care Resident Assessment Instrument Users Manual (MDS 2.0 User Guide)*.

- A copy of this manual is available online at: www.hcfa.gov/medicaid/mds20/man-form.htm.

- This manual will be customized for swing bed and available at the training sessions, as well as on

the web site at
www.hcfa.gov/medicare/snfpps_swingbed.htm

Additional Forms Required

In addition, the discharge and re-entry tracking forms are required to track the beneficiary's movement into and out of the post-acute facility.

SB-MDS Completion

Completion and Locking
- Completion date on SB-MDS (item 45) must be within 14 days of the ARD (item 10)
- A Medicare claim may not be submitted until the SB-MDS has been successfully accepted into the national database

Like all MDS assessments, those performed for Medicare beneficiaries must be performed according to the clinical rules in the *MDS 2.0 User Guide*. This means that the SB-MDS should be completed, and signed by the RN within 14 days of the Assessment Reference Date (ARD) indicated in item 10.

- The ARD is the last day of the "look-back" or observation period used to evaluate the patient for the SB-MDS. The ARD establishes a common date on which the observation period ends for all items of the SB-MDS. The ARD must be set within the window of days specified on the Medicare Assessment Schedule. (See page 22)

- The completion date indicated in SB-MDS item 45 must be within 14 days of the date entered in item 10 (ARD).

- Editing and revision may take place until the SB-MDS is entered into the National Assessment Collection Database (referred to as the national database).

- Transmission to the national database must be within 14 days of the signature date (item 45).

- The assessment is considered final when accepted into the national database

    - After acceptance, changes must be made either by submitting a correction or an inactivation

Example: ARD = 7/6/2002
Completion Date = 7/19/2002
Transmission Completed = 8/1/2002

Only those assessments that have been successfully accepted by the national database may be submitted to the Fiscal Intermediary (FI) for Medicare payment.

SB-MDS Corrections

SB-MDS Corrections
- Change to the SB-MDS that results in a different RUG-III group than previously billed
- Based on a clinical reason (PM A-01-12 applies)

or

- Different beneficiary
- Wrong reason for assessment

Correction Policy is set forth in *the MDS 2.0 User Guide,* HCFA Pub. 13-3 and Program Memorandum A-01-121 entitled, "*Skilled Nursing Facility Adjustment Billing: Adjustments to HIPPS Codes Resulting from MDS Corrections.*"

- When a correction of the SB-MDS results in a different RUG-III group than what was already billed, the provider must submit an adjustment bill

Example: SB-MDS item 31b "number of stage two ulcers"
Facility reported "zero" when there were actually three ulcers present

- Detailed claim coding requirements may be found in Chapter 3 (billing section).
- A new assessment is not considered a correction
- You may **not** adjust a bill to reflect an SB-MDS correction once the claim has been medically reviewed

The Grouper (Raven-SB)

Grouper (Raven-SB)
- SB-MDS data entry software program
- Assigns resident into RUG-III category

The resident data necessary to classify a resident into one of the RUG-III groups is contained on the SB-MDS. A software program called a "Grouper" is required to assign residents to the appropriate group.

- The swing bed facility enters SB-MDS information into the software program
- Standard Grouper software product is RAVEN-SB, available to all providers free of charge
- RAVEN-SB is accessible by downloading from the CMS web site at www.hcfa.gov/medicare/snfpps.htm

The Grouper is structured into a hierarchical order based on nursing and therapy resource utilization and services provided.

- A record can often be classified into more than one RUG-III group
- The Grouper assigns each record to the RUG-III group with the highest payment amount (this is based on the Case Mix Index which reflects resource utilization and does not take into account any "add-on" payments)

The RUG-III Classification System

Section 1888(e)(4) of the law requires that the Federal rates be adjusted for a case mix system. To determine the appropriate payment rate, the swing bed facility must classify its resident's into a RUG-III group.

The principle goal of case mix measurement is to identify patient characteristics associated with measured resource use and subsequently translating that data into payment level indices.

RUG-III Classifications

- 7 Major Categories
- 44 Sub-groups

The RUG-III classification represents the following:

- Seven major categories representing the first level of classification
- Subdivided into 44 groups based on ADL scores, nursing rehabilitation and signs of depression, taken from SB-MDS data elements
- Arranged in **hierarchical order** (highest utilization top group) based upon amount and type of service or resource

RUG-III Classification Codes

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-III CODES
REHABILITATION			
ULTRA HIGH **Rx 720 minutes** a week minimum At least 2 disciplines, 1st -5 days, 2nd - at least 3 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RUC RUB RUA
VERY HIGH **Rx 500 minutes** a week minimum At least 1 discipline - 5 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RVC RVB RVA
HIGH **Rx 325 minutes** a week minimum 1 discipline 5 days a week	13-18 8-12 4-7	NOT USED NOT USED NOT USED	RHC RHB RHA
MEDIUM **Rx 150 minutes** a week minimum 5 days across 1, 2 or 3 disciplines	15-18 8-14 4-7	NOT USED NOT USED NOT USED	RMC RMB RMA
LOW **Nrsg. Rehab 6 days** in at least 2 activities and Rehabilitation therapy Rx 3 days/ 45 minutes a week minimum	14-18 4-13	NOT USED NOT USED	RLB RLA
EXTENSIVE SERVICES - (if ADL <7 classifies to Special Care) **IV feeding** in the past 7 days (30a) **IV medications** in the past 14 days (38ac) **Suctioning** in the past 14 days (38af) **Tracheostomy care** in the last 14 days (38ag) **Ventilator/respirator** in the last 14 days (38ail)	7-18 7-18 7-18	new grouping: count of other categories code into plus IV Meds + Feed	SE3 SE2 SE1
SPECIAL CARE -- (if ADL <7 classifies to Clinically Complex) **Multiple Sclerosis** (25e) and an ADL score of 10 or higher **Quadriplegia** (25f) and an ADL score of 10 or higher **Cerebral Palsy** (25c) and an ADL score of 10 or higher **Respiratory therapy** (38bd must = 7 days) **Ulcers**, pressure or stasis; 2 or more of any stage (31a,b,c,d) and treatment (34a, b,c,d,e,g,h) **Ulcers,** pressure; any stage 3 or 4 (32) and treatment (34a,b,c,d,e,g,h) **Radiation therapy** (38ae) **Surgical, Wounds** (33c) and treatment (34f,g,h) **Open Lesions** (33b) and treatment (34f,g,h) **Tube Fed** (29b**) and Aphasia** (25b) and feeding accounts for at least 51 percent of daily calories (30a=3 or4) OR at least 26 percent of daily calories and 501cc daily intake (30b=2,3,4 or 5) **Fever (27c) with Dehydration** (27a), **Pneumonia** (26a**), Vomiting** (27f) or **Weight loss** (28a 3a) **Fever (J1h) with Tube Feeding** (K5b) and, as above, (30=3 or 4) and/or (30b = 2,3,4,or 5)	17-18 15-16 7-14	NOT USED NOT USED NOT USED	SSC SSB SSA

CATEGORY	ADL INDEX	END SPLITS	MDS RUG-III CODES
CLINICALLY COMPLEX --			
Burns (33a)	17-18D	Signs of Depression	CC2
Coma (17) and Not awake (36 = d) and completely ADL dependent (23aa, 23ba, 23ha, 23ia = 4 or 8)	17-18		CC1
Septicemia (26b)	12-16D	Signs of Depression	CB2
Pneumonia (26a)	12-16		CB1
Foot / Wounds (35b,c**) and treatment** (35c)	4-11D	Signs of Depression	CA2
Internal Bleed (27e)	4-11		CA1
Dialysis (38ab)			
Tube Fed (29b) and feeding accounts for: at least 51% of daily calories (30a = 3 or 4) OR 26% of daily calories and 501cc daily intake (30b = 2, 3, 4 or 5)			
Dehydration (27a)			
Oxygen therapy (38ad)			
Transfusions (38h)			
Hemiplegia (25d) and an ADL score or 10 or higher			
Chemotherapy (38aa)			
Physician Visits and order changes (No. Of Days in last 14 that they occurred visits >=1 days and order changes >=4 days; or visits >=2 days and order changes on >=2 days			
Diabetes mellitus (I1a) and injections on 7 days (O3 >= 7) and order changes >=2 days (41 >= 2)			
IMPAIRED COGNITION Score on MDS2.0 Cognitive Performance Scale >= 3	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	IB2 IB1 IA2 IA1
BEHAVIOR ONLY Coded on MDS 2.0 items: 4+ days a week - wandering, physical or verbal abuse, inappropriate behavior or resists care; or hallucinations, or delusions checked	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	BB2 BB1 BA2 BA1
PHYSICAL FUNCTION REDUCED No clinical conditions used	16-18 16-18 11-15 11-15 9-10 9-10 6-8 6-8 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving	PE2 PE1 PD2 PD1 PC2 PC1 PB2 PB1 PA2 PA1
			Default

*To qualify as receiving Nursing Rehabilitation, the rehabilitation must be in at least 2 activities, at least 6 days a week. As defined in the *Long Term Care RAI Users Manual, Version 2* and the SB-Manual activities include: Passive or Active ROM, amputation care, splint or brace assistance and care, training in dressing or grooming, eating or swallowing, transfer, bed mobility or walking, communication, scheduled toileting program or bladder retraining

RUG-III CLASSIFICATION GROUPS

See the RUG-III Codes Chart on pages 10-11 for more clinical criteria information.

Rehabilitation
- Five sub-categories
- Based on minutes per week

Rehabilitation

The rehabilitation category is organized based on resource utilization. Within this category there are **five** subcategories, ranging from ultra high rehabilitation to low rehabilitation based upon:

- The number of minutes of rehabilitative services received in a week
- Combinations of rehabilitation disciplines providing services
- Receipt of nursing rehabilitative services
- Patient ADL scores

Rehabilitation Sub-categories:

- Ultra High
  (Minimum of 720 mins/wk, 2 disciplines – 1st 5days, 2nd at least 3 days)
- Very High
  (Minimum of 500 mins/wk, 1 discipline 5 days)
- High
  (Minimum of 325 mins/wk, 1 discipline 5 days)
- Medium
  (Minimum of 150 mins/wk across 1,2 or 3 disciplines)
- Low
  (Nursing Rehabilitation 6 days in 2 activities and Rehabilitation therapy treatments 45 mins/wk)

Extensive Services

Extensive Services
- Minimum of 7 for ADL score, *and*
- Receipt of one of the defined services in prescribed timeframe

Residents in the "Extensive Services" category must have received, in the past 14 days, the services indicated below, **and** have an ADL score that is at least 7.

- Intravenous medication
- Tracheotomy care
- Required a ventilator/respirator
- Required suctioning **or**
- In the past seven days required intravenous feedings

The classification is further subdivided by assigning one point for each of the clinical conditions below. Each patient is assigned a score of 0-5 based on five criteria. The score is used to classify the patient into one of three RUG-III groups within this category.

Points:
0 or 1 = SE 1
2 or 3 = SE 2
4 or 5 = SE 3

For the following five criteria, the patient receives one point for each criterion that applies to her or him.

The first three criteria are the presence of a clinical characteristic that classifies the resident into one of the following groups:

Special Care:	1 point
Clinically Complex:	1 point
Cognitively Impaired:	1 point

The fourth and fifth criteria are:

Receives IV Feeding:	1 point
Receives IV Medications:	1 point

Extensive Services, continued:

Example A:
A person who has an ADL score of at least 7, and qualifies for both the Cognitively Impaired and Special Care categories will be assigned a score of 2 and classify into the SE2 group.

Example B:
A patient with an ADL score of at least 7, who is ventilator dependent and requires suctioning will be assigned a score of 0 and classify into the SE1 group.

Special Care

Special Care
- Minimum one clinical condition

Residents in the Special Care Group will have at least one of the conditions listed below.

In addition, anyone qualifying for Extensive Care, but whose ADL score was less than 7, will be grouped into Special Care.

- Multiple sclerosis (ADL score 10 or more)
- Cerebral palsy (ADL score 10 or more)
- Quadriplegia (ADL score 10 or more)
- Receiving respiratory therapy seven days per week
- Treatment for pressure or stasis ulcer, on two or more body sites
- Has surgical wound(s) or open lesions and has received treatment for them
- Aphasic and Tube feeding (comprising at least 26% of daily caloric intake and at least 501 ml of fluid through the tube per day)
- Receiving radiation therapy
- Fever in combination with
  - -Dehydration,
  - -Pneumonia,
  - -Vomiting,
  - -Weight loss, **or**
  - -Tube feedings

Clinically Complex
- Resident will have one or more of 14 identified clinical characteristics

Clinically Complex

Residents will qualify for Clinically Complex if they have one or more of the following:

- Burns
- Coma
- Septicemia
- Pneumonia
- Internal bleeding
- Dehydration
- Hemiplegia in combination with(ADL score of 10 or more)
- Receive chemotherapy
- Tube feedings comprising at least 26% of daily caloric intake and at least 501 ml of fluid through the tube per day
- Treatments for foot wounds
- Transfusions
- Diabetes **and** receive injections seven days per week **plus** have two or days with physician **order changes** in the past 14 days
- Received oxygen therapy in the past 14 days
- Over a 14 day period had:
  One or more days on which there were **physician visits** and at least four days when **order changes** occurred
  Or
  Two or more days on which there were physician visits and at least two or more days on which order changes occurred

Impaired Cognition, Behavior Only And Physical Function Reduced

Impaired Cognition
&
Behavior Only
&
Physical Function Reduced

- Are not automatically covered or non-covered
- Must meet existing criteria

Residents placing in the following three RUG-III groups; Impaired Cognition, Behavior Only, and Physical Function Reduced, may be covered by Medicare with proper documentation and medical justification.

Impaired Cognition

Patients in the Impaired Cognition category:

- Have SB-MDS 2.0 scores on the Cognitive Performance Scale of 3,4, or 5.
- May receive restorative nursing services

Behavior Only

Patients with ADL scores of 10 or less who have exhibited any behaviors listed below in four of the last seven days will classify for the Behavior Only category.

- Resisting care
- Combative
- Physically/verbally abusive
- Wandering
- Experiencing hallucinations or delusions

Physical Function Reduced

- May receive restorative nursing services
- Receive assistance with ADLs

REQUIRED ASSESSMENT TYPES TO SUPPORT PPS BILLING

Required Assessments
- Regularly scheduled
- Readmission/Return
- Other Medicare Required Assessment
- Clinical Change Assessment

Under the SNF PPS, swing bed providers must complete the following types of assessments:

- Regularly Scheduled Assessment
- Readmission/Return Assessment
- The Other Medicare Required Assessment (OMRA)
- Clinical Change Assessment (CCA)

Other Medicare Required Assessment (OMRA)

The Other Medicare Required Assessment
- Must be completed if a skilled level of care is ongoing after therapy cessation
- The ARD must be set on days 8, 9 or 10
- Rehabilitation RUG-III rate continues from therapy end to OMRA ARD
- Not needed if discharged or unskilled level of care at day eight after therapy

The OMRA must be completed only if the beneficiary continues to have a skilled level of care requirement after the discontinuation of therapy. The OMRA assessment reference date must be set on day eight, nine, or ten after the last day of all rehabilitative services.

- Coverage continues from the end of therapy until the OMRA assessment reference date at the rehabilitation rate to which the beneficiary classified.

- If the beneficiary is discharged or no longer needs a skilled level of care before the eighth day following the end of therapy, no OMRA is required.

- If the beneficiary was receiving only small amounts of therapy, and was not classified into a RUG-III rehabilitation group, no OMRA is required

The OMRA **may not be** used to indicate changes in the amount or frequency of services or to show reductions in the number of therapy disciplines provided.

Reminder:
Waiting to verify the stability of the beneficiary in the absence of skilled nursing or rehabilitation is **not** always appropriate. Facilities should not routinely extend the therapy billing period to the last day (day 10) of the allowable OMRA Assessment Reference Dates.

Clinical Change Assessment (CCA)

The Clinical Change Assessment (CCA)
- Identified by a reason for assessment
- Identifies a change in a resident's condition/status that is noted on a consistent basis

The Clinical Change Assessment allows providers to complete and transmit SB-MDS data reflecting a significant clinical change in a resident's condition/status that affects the beneficiary's RUG-III group. The CCA is utilized in the circumstances listed below:

- A decline or improvement in resident health status
- The change will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions
- Affects more than one area of the resident's health status
- Requires interdisciplinary review/revision to the care plan

REQUIRED SCHEDULE FOR SB-MDS COMPLETION

The following schedule applies to **newly admitted/re-admitted** beneficiaries whose stay is expected to be covered during the first 30 days.

For the purpose of counting days
Day 1 = (Admission/re-admission) and notification of non-coverage if known

Medicare Assessment Schedule

Assessment	Applies to the following Medicare Part A days
Medicare 5-Day	1-14
Medicare 14-Day	15-30
Medicare 30-Day	31-60
Medicare 60-Day	61-90
Medicare 90-Day	91-100

Medicare Assessment Schedule
- Day 5
- Day 14
- Day 30
- Day 60
- Day 90

See Chart on page 22, *Medicare Assessment Schedule*, which includes grace days.

Grace Days

A specific number of grace days are allowed for each scheduled Medicare assessment. (Refer to *Medicare Assessment Schedule* on page 22). The use of grace days is acceptable and permitted for patients with any condition.

Grace Days
- Acceptable and permitted

Medicare 5-Day Assessment And Use Of Grace Days

Days one through five are optimal assessment reference dates (ARD); however, days six through eight are also acceptable and for some residents, (e.g., those receiving rehabilitation services) the most appropriate.

5-day Assessment

- Grace period of three days
- Allowed to use up to and including day eight as the assessment reference date

14, 30, 60, 90-day Assessment

- Grace period of five days
- Allowed to use up to five additional days as the assessment reference date.

Grace Days

Grace Days
- Acceptable for 5-day ARD to fall within the grace days

A specific number of grace days are allowed for setting the assessment reference date (ARD) for each scheduled Medicare assessment.

There are three principal reasons for the use of grace days:

1. It allows for the situation where the beneficiary is not able to begin therapy at the time of admission due to an unstable condition; therefore, the beneficiary does not begin receiving a therapy program until days five, six or seven of the SNF/swing bed stay. In order to capture the rehabilitation therapy necessary for the beneficiary's classification into one of the rehabilitation therapy RUG-III groups, the facility will choose to set the ARD on one of the grace days.

2. It allows for the classification into one of the two highest RUG-III subcategories of Ultra High and Very High by capturing the minimum level of

services received by the beneficiary in the first seven days of his or her stay.

3. It allows clinical flexibility in setting ARDs,

Reminder:
If a facility chooses to routinely use grace days, it may be subject to audit to determine if the ARD is accurately reflected.

MEDICARE ASSESSMENT SCHEDULE

DAY 1= Admission or Re-Admission

Medicare MDS Assessment Type	Reason for Assessment (SB-MDS Item 11b code)	Assessment Reference Date *(Based on start of a Part A stay)	Assessment Reference Date Grace Days	Number of Days Authorized for Coverage and Payment
5- Day	1	1-5**	6-8**	14
14-Day	7	11-14	15-19	16
30-Day	2	21-29	30-34	30
60-Day	3	50-59	60-64	30
90-Day	4	80-89	90-94	10

* The assessment reference date is the last date of the observation period for the clinical assessment. The timeliness requirements are calculated using the first day of the Medicare Part A Covered Stay as “day 1”

** If a patient expires or transfers to another facility before day 8, the facility will still need to prepare an SB-MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise, the days will be paid at the default rate

A customized 2-page SB-MDS has been developed for use by swing bed hospitals. A draft of the SB-MDS for swing bed hospitals is available on the CMS web site at http://www.hcfa.gov/medicare/snfpps.htm.

Two other assessments are required, when appropriate:

- An Other Medicare Required Assessment (OMRA) is required when all rehabilitative services are discontinued for a patient.

- A Clinical Change Assessment (CCA) is required when there is a significant change in the patient’s condition/status. The criteria for determining a significant change in clinical condition are shown on page 19 of this chapter and are described in detail in the *Swing Bed SB-MDS Training Manual*.

FACTORS WHICH IMPACT THE ASSESSMENT SCHEDULE

Resident Expires Or Transfers:

Assessment Schedule Interruptions
- Resident expires
- Resident transfers
- Physician hold
- Level of care change

If a patient expires or transfers to another facility before day eight, the facility is required to prepare an assessment as completely as possible for RUG-III classification and Medicare payment purposes, otherwise days will be paid at the default rate.

"Medical Predictability" Delay

A patient may establish Part A more than 30 days after the qualifying stay when a medical appropriateness exception is made in accordance with Section 3131.3B of the Medicare Intermediary Manual, Pub 13-3. The provider should start the Medicare assessment schedule from the first day of the Part A Medicare covered stay.

Assessments Past Mandated Time Frames

Assessments Outside The Regular Medicare Schedule
- May be coded with two reasons for assessment
- May replace regularly scheduled assessment

Assessments other than regularly scheduled assessments (e.g., Clinical Change Assessment (CCA), or the Other Medicare Required Assessment (OMRA)) may be completed during the regular assessment schedule. If the assessment reference date of either assessment coincides with the assessment window for a regularly scheduled assessment, a single assessment may be coded as both a regularly scheduled assessment, (5,14, 30, etc.) and a CCA **or** OMRA.

Under these conditions the CCA or OMRA takes the place of the regularly scheduled assessment. For example, if the OMRA was completed on day 28 of the stay, it replaces the 30-day assessment. However, if the OMRA occurred on day 40, it would not replace the 30-day assessment.

Early Assessments
- Paid at the default rate
- In next payment block
- For number of days assessment was early

Early Assessments

An assessment should be completed according to the designated swing bed assessment schedule. If an assessment is performed **earlier than the schedule indicates** the provider will be paid at the default rate (Default = the lowest rate of reimbursement of the RUG III groups) for the number of days the assessment was out of compliance. The default rate is assigned to days at the start of the new payment block.

Example:

Admission = **5/1/02**
ARD 14-day Assessment = 5/9/02
The allowable days for setting the ARD
are days 11-14 (5/11,12, 13, or 14)
Default code (AAA00) assigned to Days 5/15 and 5/16 (number of days out of compliance with the assessment schedule)

Late Or Missed Assessment Criteria

Late or Missed Assessments
- No financial penalty if during allowed grace period
- Paid at default through ARD for covered services if done after grace period

An assessment should be completed as quickly as possible after realizing that it is past the required timeframe on the assessment schedule. Return to the regular Medicare schedule once the late assessment is completed. Grace days may be applied as follows:

- If a late/missed assessment is completed within the mandated grace period, no financial penalty is assessed under Medicare. (However, patterns of late assessment may result in medical review of claims submitted.)

  If the assessment is completed after the mandated grace period, payment will be made at the default rate for covered services, from the first day of the assessment period to the ARD of the late assessment.

Non-Compliance With The Assessment Schedule

According to the Code of Federal Regulations (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at a default rate. Frequent early or late assessments may result in onsite review of assessment scheduling practices.

Transition Criteria Effective The First Day Of PPS

Transition into PPS
- Facility must perform 5-day assessment on or after first day of SB-PPS

The swing bed facility must perform a 5-day assessment on or after Day One of the facility's entry into SB-PPS.

See Chapter 3 (billing section) for claim completion instructions.

Any patient who is in a covered SB stay on the date the facility comes under SB-PPS will not have his/her coverage terminated on the basis of the change in the method of making level of care determinations under the PPS for the duration of that covered stay. Therefore, if the patient was "skilled" using the level of care criteria in place prior to the transition to SB-PPS, the beneficiary continues to be considered skilled until one of the following occurs:

- last day of the Part A benefit period (benefits are exhausted)
- date of discharge from the swing bed
- date the condition/service that required skilled care is resolved/eliminated

COVERAGE

SKILLED LEVEL OF CARE

A prerequisite for coverage under the extended care benefit in a swing bed hospital is the beneficiary's need for and receipt of a skilled level of care and the fact that all services must be reasonable and necessary to diagnose or treat the beneficiary's condition.

The Establishment Of A 5-Day Presumption Of Coverage

Skilled Level of Care and FY 2000 Final Rule for SNF PPS

- Established 5-day presumption for meeting a skilled level of care

The FY 2000 Final Rule for SNF PPS redefined and further clarified the definition of skilled care by establishing a 5-day presumption of coverage. The period immediately following hospitalization is usually the period during which a beneficiary's condition is most unstable. During these initial days of the swing bed stay, staff will:

- Initiate skilled nursing and/or rehabilitation services
- Complete the assessment of the beneficiary's clinical characteristics and care needs

However, this presumption of coverage only applies if the beneficiary is receiving services that are reasonable and necessary to diagnose or treat the beneficiary's condition.

5-Day Presumption
- Requires placement in Top 26 RUG-III groups
- Services must be reasonable and necessary
- Applies to Medicare 5-day assessment only
- Extends from admission up to and including the ARD and grace days, if utilized

The 5-Day Presumption Definition

When the initial Medicare required assessment (5-day assessment) results in a beneficiary being correctly assigned to one of the upper 26 RUG-III groups, this effectively creates **a presumption of coverage for the period from admission up to and including the ARD for that assessment.**

This presumption is valid through the ARD of the 5-day assessment.

Determination Of Skilled Care Beyond The 5-Day Presumption

Continuation of coverage once established by the RUG-III presumption is dependent upon the subsequent course of the resident's actual condition and care needs as documented in the medical record.

The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the beneficiary's condition and care needs, thus meeting the skilled care definition. If the services are not medically necessary, a decision of non-coverage should be made.

Clarifications Of The Presumption Of Coverage

The following scenarios further clarify that a beneficiary's classification to one of the upper 26 RUG-III groups triggers the presumption of coverage under the initial 5-day Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge**.**

- **Routine swing bed admission directly from qualifying hospital stay**

  If the beneficiary is admitted for SNF-level care **immediately** following a 3-day qualifying hospital stay (regardless of whether the acute care hospital stay was in the swing bed facility or not), **there is a presumption** that he or she meets the Medicare level of care criteria. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

- **Admission for SNF-level care does not immediately follow discharge from the qualifying hospital stay, but occurs within 30 days (as required under the "30-day transfer" rule)**

  If the beneficiary is discharged from the hospital to a setting other than the SNF-level services provided in the swing bed facility, the **presumption of coverage does not apply**, even if the beneficiary's return to the swing bed facility for SNF-level services occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in file.

- **Resident is re-hospitalized and then returns**

  If a beneficiary who has been in a covered Part A stay requires re-admission to a hospital (either the swing bed hospital or another hospital), and is transferred directly back to the swing bed to

receive SNF-level services, **there is a presumption** that he or she meets the level of care criteria upon re-admission. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date of the assessment, which must occur no later than the eighth day of the stay.

- **Routine swing bed admission directly from qualifying hospital stay, but initial portion of swing bed stay covered by another insurer (Medicare as Secondary Payer)**

  When a beneficiary goes directly from a qualifying hospital stay to the swing bed for SNF-level care, but the initial portion of the post acute stay is covered by another payer that is primary to Medicare, Medicare payable coverage would not start until coverage by the insurer ends. The Medicare required schedule of assessments would not begin until the first day of Medicare payable coverage. If the other insurer's coverage ends within the first eight days of the stay, the presumption lasts through the assessment reference date of the 5-day assessment or, if earlier, the eighth day of the stay. Thus, if the other insurer's coverage lasts through the eighth day of the stay, **there is no presumption.**

- **Beneficiary receives a notice of non-coverage upon admission and requests a demand bill**

  In this situation, a Medicare 5-day assessment was not performed because the SB's clinical staff determined upon admission that the beneficiary did not meet the level of care criteria for coverage. **Since no 5-day assessment was performed, the medical review would be based on the coverage criteria** described in Transmittal 18 of the Medicare Program Integrity Manual (HCFA PUB. 83). If medical review indicated that the services should have been covered, the days

would be paid at the default rate since no 5-day assessment was actually performed.

- **Re-admission for post-acute swing bed care within 30 days after discharge from initial swing bed stay—no intervening hospitalization**

  If a beneficiary is initially admitted to the swing bed directly following a covered Part A acute care stay, the presumption for that stay is applicable.

  However, if that beneficiary is discharged (*not* to an acute care facility) and is then subsequently readmitted to the swing bed facility, **there is no presumption** applicable to the second swing bed admission. (If the beneficiary **is** transferred to a hospital, and returns directly to the swing bed, presumption applies and a new 5-day assessment is required.)

- **Initial, non-Medicare swing bed stay followed by qualifying hospitalization and re-admission to a swing bed facility for a Medicare-covered extended care stay**

  Dually eligible (Medicare/Medicaid) beneficiaries whose initial post acute swing bed stay is either Medicaid-covered or private pay, **are eligible for the Medicare presumption of coverage** when re-admitted to the swing bed for SNF-level services following a **qualifying** hospitalization. (For example, if there was no 3-day qualifying hospitalization prior to the first swing bed stay, but there one prior to the second swing bed admission.)

- **Transfer from one extended care (i.e., SNF-level) facility to another**

  There is **no presumption of coverage** in cases involving transfer of a beneficiary from one SNF-level provider to another. The presumption applies only to the SNF-level stay that

immediately follows the qualifying hospital stay. Similarly, in cases involving transfer of a beneficiary from a swing bed hospital to a SNF, the presumption applies only when the beneficiary stopped receiving inpatient acute care services and initiated the extended care portion of the stay in the swing bed hospital. The swing bed services payable under the SNF PPS are eligible for the presumption. However, the presumption does not apply to beneficiaries transferring to a SNF after receiving extended care services in a swing bed hospital.

Bear in mind that the presumption was deliberately designed to create a very high probability of identifying those situations that involve a need for skilled care. **Accordingly, we do not anticipate that there will be a significant number of cases in which a beneficiary qualifies for the presumption and yet does not actually require any skilled care.**

However, as indicated in the FY 1998 SNF PPS Final Rule (64 FR 41668-69), if it becomes apparent in actual practice that this is not the case with regard to certain specific criteria under the RUG-III classification system (e.g., the 14-day “look-back” provision), CMS reserves the right to reassess the validity of the presumption’s use of those criteria.

APPLICATION OF THE RUG-III CLASSIFICATION TO EXISTING LEVEL OF CARE CRITERIA

Application of RUGs to Existing Criteria
- Streamlines and simplifies process for identifying skilled level of care
- Determines a prospective payment variable with resource utilization

The existing criteria and the RUG-III classifications represent two approaches toward achieving the same objective; the determination of a covered level of care as defined by Medicare regulations. It is desirable where possible, to reconcile specific differences that may exist between the two. In the swing bed facility context, the RUG-III system can serve two distinct, but related purposes.

First, it streamlines and simplifies the coverage determination process for new admissions through the presumption of coverage applied to beneficiaries in one of the highest 26 of the 44 RUG-III groups. For beneficiaries in the lower 18 RUG-III groups, level of care determinations are performed on an individual basis using existing administrative criteria.

Secondly, it prospectively determines the actual level of Part A per diem payment.

CLINICAL ELIGIBILITY

A beneficiary is eligible for post-acute hospital extended care facility services when receiving skilled care on a daily basis under the Swing Bed PPS.

Eligibility Requirements
- Residents in lower 18 are not automatically covered or non-covered

Residents in the lower 18 RUG-III categories are not automatically covered or non-covered. Instead, the beneficiary must receive an individual level of care determination and meet the existing level of care definition to be covered. If the conditions described are not met, a notice of non-coverage must be given.

Modifications To Coverage Criteria

Existing Criteria
- Removed subcutaneous injections and hypodermoclysis
- Modified Catheters to suprapubic catheters only

The FY 1998 SNF PPS Final Rule modified the existing administrative criteria for meeting the definition of a skilled level of care. **The coverage criteria are effective for swing bed facility services for dates of service starting with each facility's next cost report year beginning on or after July 1, 2002**. The following represent the important changes to "direct skilled services". Please also refer to the Eligibility Comparison Charts on the pages 34-38.

Direct Skilled Services Removed:

- Subcutaneous Injections
- Hypodermocylsis

Direct Skilled Services Modified:

- NG tube, gastrostomy, jejunostomy have been modified to: Feedings must equal 26% of daily calories and a minimum of 501 ml of fluid per day

- The qualification of catheters as meeting the definition of direct skilled services has been modified to include suprapubic catheters only

COMPARISON AND RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

TECHNICAL ELIGIBILITY	
Prior to SNF PPS	**Changes with SNF PPS Final Rule**
3-day qualifying stay	Remains the same
Transferred within 30 days of hospital stay of three consecutive days	Remains the same
Physician certification as to the need for skilled care (admission/by day 14 and every 30 days thereafter)	Physician, Nurse Practitioner, or Clinical Nurse Specialist ***may initially*** certify to the Need for skilled care ***or*** correctness of the RUG-III. ***Re-certifications*** are for the ongoing need of skilled services
Medical predictability (continuation treatment is inappropriate from a medical perspective)	Remains the same
Treated for a condition which was treated during a qualified stay, ***or*** which arose while in a SNF/swing bed for a treatment of a condition for which the beneficiary previously was treated in the hospital	Remains the same

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

Prior to SNF PPS	Changes with SNF PPS Final Rule
Skilled nursing or skilled rehabilitation on a daily basis	Remains the same
Performed by or under direct MD supervision	Remains the same
Management/evaluation of the Plan of Care	Remains the same
Observation and assessment of the Plan of Care	Remains the same
Teaching and training activities: *To teach self-maintenance;* *Examples:* • Self-injection • Newly diagnosed diabetic insulin injection/diet/observation foot care precautions • Gait training and prosthesis care • Recent colostomy/ileostomy care • Self-catherization and self-GT feedings care and maintenance CVP's/Hickman catheters • Care of braces, splints, orthotics, associated skin care • Specialized dressings or skin treatment	Requires skills of a technical/professional for the teaching of a self maintenance program

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

DIRECT SKILLED SERVICES	
Prior to SNF PPS	**Changes with SNF PPS Final Rule**
IV, IM, SC injections	IV, IM injections only
Hypodermoclycis, IV feedings	IV feedings only
NG tube, gastrostomy, jejunostomy	**Modified to:** feedings 26 percent of QD calories and a minimum of 501 ml fluid per day
Naso-pharyngeal tracheotomy aspiration	Remains the same
Insertion, sterile irrigation, replacement catheters/care of suprapubic catheter and insertion/ care of catheter adjunct to active treatment of a disease	Suprapubic catheters only
Application of dressings with prescription medications and aseptic techniques	Remains the same
Treatment of decubitus ulcers. Severity of grade 3 or worse or widespread skin disorder	Remains the same
Heat treatments ordered by MD requiring skilled observation	Remains the same
Rehabilitation nursing procedures includes related teaching adaptive aspects of nursing and part of active treatment necessitating skilled nursing; e.g., institution of bowel and bladder training programs	Remains the same
Initial regimen involving administration of medical gases such as bronchodilator therapy	Remains the same
Care of a colostomy/early post-op phase with associated complications	Remains the same

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

SKILLED PHYSICAL THERAPY	
Prior to SNF PPS	**Changes with SNF PPS Final Rule**
Directly related written plan of treatment	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Requires knowledge/skills/ judgment of qualified professional	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Services must be considered under acceptable standards of clinic al practice	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Expectation of improvement of restorative potential in a reasonable and predictable period of time, **or** establishment of a safe and effective maintenance program*	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Applications • Hot Packs Hydrocollator infrared, paraffin baths **only** in the presence of complicating condition (e.g., open wounds) • Gait training • Ultrasound, short-wave, diathermy • ROM tests • Therapeutic exercises	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
** The actual provision of maintenance therapy does not generally require the skills of a licensed therapy professional*	

SKILLED OCCUPATIONAL THERAPY	
Prior to SNF PPS	**Changes with SNF PPS Final Rule**
Ordered by a physician to improve or restore function	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Applications • Evaluation/ Re-Evaluation of function • Teaching task oriented therapeutic activities • Plan/implement/supervise individualized therapeutic activities and sensory integration functions • Testing of compensatory techniques • Design/fabrication and fitting orthotic or self help devices • Vocational/pre-vocational	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

SPEECH THERAPY	
Prior to SNF PPS	**Changes with SNF PPS Final Rule**
Directly related written plan of treatment	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Requires knowledge/skills/judgement of qualified professional	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Services must be considered under acceptable standards of clinical practice	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Expectation of improvement; i.e., restorative potential in a reasonable and predictable period of time ***or*** establishment of a safe and effective maintenance program*	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Services necessary for diagnosis and treatment of speech and language disorders	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
Applications • Restoration therapy • Establishment program* • Diagnostic and evaluation services • Therapeutic services • Services for the treatment of dysphagia	Skilled rehabilitation services are captured within the RUG-III rehabilitation groups
** The actual provision of maintenance therapy does not generally require the skills of a licensed therapy professional*	

COVERAGE CLARIFICATIONS

Skilled Observation And Assessment Of The Resident's Changing Condition

Skilled Observation and Assessment
- Identification and evaluation for treatment plan modifications
- Requires skills technical or professional

Observation and assessment constitutes skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modifications of treatment or for additional medical procedures until his or her condition is stabilized. (42 CFR 409.33)

The following are examples of skilled observation:

Example A:
Beneficiary with diagnosis of CHF may require continuous close observation for:

- Signs and symptoms of decompensation
- Abnormal fluid balance
- Medication side effects signaling the need for an adjustment in the medical treatment

Example B:
Beneficiary with diagnosis of surgical hip replacement may require observation and assessment for:

- Postoperative complications
- Presence of co-morbid conditions/physical problems
- Acute psychological symptoms such as depression, anxiety or agitation
- To ensure safety of resident in the case of suicidal or homicidal behaviors.

The need for these services must be documented by physicians orders or nursing/ therapy notes.

Overall Management And Evaluation Of A Care Plan

Management and Evaluation of a Care Plan
- Based on a physician's order
- Requires skilled technical or professional personnel
- Overall patient condition must be documented in the medical record to support the need

The development, management and evaluation of a patient care plan based on physician orders constitutes skilled services when:

- The beneficiary's physical and mental condition requires skilled level technical or professional personnel to safely plan, monitor and manage care

- The plan involves a variety of personal care services and the aggregate of those services, in light of the patient's condition, requires the involvement of technical or professional personnel

Although a properly instructed person could perform these services, the ability to understand the relationship between services and the ultimate affect of one upon the others is essential. In this circumstance, the skills of a nurse are required even though the individual services may not be skilled. (42 CFR 409.33 (i)).

Reminder: The overall condition must be documented in the medical record to support the finding that recovery and safety can be ensured only if the total care is planned, managed and evaluated by skilled technical or professional personnel.

Example Of Aggregate Of Services

Beneficiary with history diabetes mellitus and angina pectoris is recovering from an open reduction of a fractured femur requiring:

- Skin care per diabetic protocol
- Appropriate oral medications
- Diabetic diet
- Exercise program to preserve muscle tone and body condition
- Observation for signs and symptoms of complication and/or deterioration as a result of restricted activity

Patient Education Services

Patient Education
- For the teaching of a self-maintenance program
- Requires technical or professional staff

Patient education services are skilled when and if the services of a technical or professional person are required to teach a patient a self-maintenance program.

Example Of Patient Education Services
Recent amputee needs skilled rehabilitative services provided by technical or professional personnel to provide the necessary gait training and prosthetic care.

Physician Order Changes And Visits

The number of days on which physician order changes and physician visits occurred are indicators of a beneficiary's clinical instability.

The Following **Are Not** Order Changes:
- Continuation or renewal of existing orders
- Clarifications of existing orders
- Sliding scale administrations

*Physician Orders That **Do Not** Qualify As An Order Change*

A physician's order to continue or renew some specified treatment or regimen is not considered to be an order change, nor would an order written solely to clarify an earlier order.

A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on sliding scale guidelines.

Physician Visits

Physician Visits
- Full or partial exam at the SNF or physician's office

A physician visit is defined as a partial or full exam at the facility or in physician's office by the following professionals:

- MD, osteopath, podiatrist, or dentist
- Primary or consulting physician
- Authorized physician's assistant
- Nurse practitioner working in collaboration with the physician

Rehabilitative Services

Rehabilitative services may begin as early as day one of the beneficiary's Part A stay. All therapeutic services must meet the following criteria to be covered by Medicare Part A:

- Ordered by a physician
- Related directly and specifically to an active written plan of treatment
- Medically reasonable and necessary
- Provided directly or under direct supervision of a licensed professional
- Coordinated with nursing services

Initial Evaluations

Initial Evaluations
- Completed during Part A stay
- May not be counted on SB-MDS
- Cost captured in the PPS Rate

The initial evaluation performed by a licensed professional therapist must be completed while the beneficiary is in a swing bed Part A stay **and not** be an evaluation that was performed while in the inpatient facility. The time spent by the therapist performing the initial evaluation and subsequently developing treatment goals and a formalized plan may not recorded as minutes of therapy on the SB-MDS. **The facility cost of doing the initial evaluation is captured in the SNF PPS rate.**

Re-evaluations

The time it takes to perform a re-evaluation may be counted in Therapy Section P of the SB-MDS, if the re-evaluation is a hands-on examination of the beneficiary. It can not be counted in item 38 if it is just an update to the existing documentation and/or a revision of a care plan that is performed once a therapy regimen is under way.

Example:
Therapist is evaluating goal achievement as part of the therapy session.

Concurrent Therapy

Concurrent therapy is defined as "the practice of one professional therapist treating more than one beneficiary at a time." It differs from group therapy in that each beneficiary may not be working on a common skill or task. **The decision to provide therapy must be driven by valid clinical judgement.**

Faxed Signatures

Faxed Signatures
- Acceptable

A therapy plan of treatment signed by a physician is acceptable when faxed to the swing bed facility. Any modifications to the original plan must be made in writing, and if done by a therapist, initialed or signed by the ordering physician within a reasonable time.

Group Therapy
- 4 or fewer beneficiaries
- May only equal 25% of weekly therapy
- 25% applicable per discipline, e.g., ST

Group Therapy

Group therapy is defined as a group of four or fewer participants working on the same activity. The group may be led by a licensed therapist, or by a licensed Physical Therapist Assistant (PTA) or a Certified Occupational Therapist Assistant (COTA) who is under the professional therapist's supervision.

The total number of minutes spent is captured individually on each group participant's SB-MDS. In addition, the following criteria apply:

- The time spent in group therapy only may equal 25% of the beneficiary's weekly therapy program time

- The 25% limit is applied separately to each individual discipline – physical therapy, occupational therapy, speech therapy (PT, OT, ST, respectively)

- The supervising therapist may not oversee/supervise any other therapy service or patient while providing group therapy supervision

Therapy Minutes
- Therapy received during the previous seven calendar days or since admission
- Not necessarily consecutive days
- RUGs represent minimum requirements
- Must be documented
- Minutes reflect actual treatment time

Minutes Of Therapy

A therapy minute reflects actual treatment received by the beneficiary, beginning with the first treatment activity or task and ending with the last procedure/apparatus completion.

The minutes of therapy received during the previous seven calendar days, or since admission, whichever is shorter, are counted and reported on the SB-MDS.

The medical record must support the minutes of therapy, like any therapeutic intervention. For therapy services, key documentation will be included in the SB-MDS, therapy progress notes, and therapy daily attendance logs.

- RUG-III rehabilitation group minute thresholds are the **minimum** number of minutes required for classification into the group

- No limits are to be placed on services provided to a beneficiary due to the facility's interpretations of minutes "allowed" by a particular RUG-III group

- Therapeutic services performed by students are **not** counted **unless** provided under the direct, personal supervision of the licensed, professional therapist

- Number of days and minutes of actual treatment received by the beneficiary (including set-up) during the 7-day 'look-back' period, as explained in the *MDS 2.0 User Guide* are counted and recorded in item 38 of the SB-MDS. No therapy minutes delivered prior to the swing bed admission may be counted.

- Treatment days and minutes need not be provided on each day of the observation period.

  Example:
  Beneficiary received physical therapy 50 minutes on second and the fourth days of the stay. This

will be recorded on the SB-MDS item 38 as two days and 100 minutes of physical therapy.

- Minutes reported on the SB-MDS are **actual time** and are **not** rounded to nearest 10 or 15 minute interval.

- PT, OT, ST provided outside the SNF may be counted and recorded on the SB-MDS if provided by qualified staff. For example, transportation time to and from the beneficiary's home before discharge is acceptable if the therapist accompanies the beneficiary **and** if the time in transport is utilized for education or discussion of the beneficiary's treatment and/or goals and for beneficiary/family conferences (Per State Operations Manual, Pub. 7, Transmittal #272 p. R64). The medical necessity of this trip must be documented in the medical record

SB-MDS Item 42

Item 42 on the SB-MDS is the record of "ordered therapies." Item 42a asks, "Has a physician ordered any of the following therapies to begin in the **first** 14 days of the stay PT, OT, or ST?"

- If the answer is yes, the number of expected minutes and days is completed in items 42b and 42c

- If the answer is no, then there is nothing reported in items 42b and 42c

If the physician order for therapy specifies ten days, the minutes are captured over ten days. In the absence of a specific time limit utilize 14 days as a standard, assuming the beneficiary continues to receive rehabilitative services.

Respiratory Therapy

The coverage provisions of respiratory therapy treatment were not altered by the implementation of

PPS and are described in the Skilled Nursing Facility Manual, Pub. 12, Section 230.10 C.

However, there is no longer a requirement to have an "under arrangement" relationship.

Therapy Supervision

Licensed professional therapists must provide or supervise the provision of the therapeutic service and coordinate the intervention with Nursing. Physical Therapy Assistants (PTA) and Certified Occupational Therapy Assistants (COTA) may provide therapy under the general supervision of the professional who must be accessible while they are providing the therapeutic service. As always, Medicare does not cover care provided by a Speech Language Pathology Assistant.

Therapy Supervision
- Provided by licensed staff
- PTA and COTA under general supervision
- Therapy aides and students require direct, personal supervision

- A licensed professional must provide all supervision. PTAs and COTAs may not supervise any other personnel.

- A therapy aide or therapy student must be under the direct, personal supervision of the professional therapist "in a manner which allows for visual contact at all times" (FY1999 SNF PPS Final Rule).

- Staff therapists supervising aides performing restorative nursing services **may not** code their time as **skilled therapy**. However**,** both the time of aides and supervising therapist may be counted under *restorative nursing.*

NOTICES OF NON-COVERAGE

Notices of Non-coverage
- Required when services are no longer skilled and/or reasonable and necessary
- Effective immediately
- Payment ends the following day

A resident's acuity level may change so that the beneficiary is no longer in need of skilled care. In such situations, no Clinical Change in Status Assessment is required.

Once skilled care is no longer required, a notice of non-coverage must be issued, effective the following day. This is based on the custodial care exclusion from coverage and takes precedence over other Program provisions.

Demand Bills

Demand Bills
- Required FI Review

Demand bills must be sent to the FI any time that the beneficiary requests the swing bed facility to do so. The beneficiary makes this request by marking the box on the notice of non-coverage that requires a claim to be billed (Skilled Nursing Facility Manual, Pub.12, Section 356.1).

Demand bills must be submitted even in cases of technical ineligibility. The FI will handle those cases differently because no medical review is necessary when the patient is not technically eligible for Part A reimbursement.

Chapter 3 (billing section) in this manual contains detailed billing instructions.

MEDICAL REVIEW PROCESS UNDER PPS

Medical Review Coverage Criteria Per:

- Program Integrity Manual Pub-83
- Medicare Intermediary Manual Pub. 13-3
- Program Memoranda

Prospective Payment Systems are per diem payments, based on clinical assessment and placement into a Resource Utilization Group (RUG-III). The methodology for medical review changed under the PPS from a review of a few itemized services to a review of the beneficiary's condition.

Swing bed facilities will be subject to the medical review guidelines found in the Medicare Intermediary Manual Pub.13-3, Program Integrity Manual Pub. 83, and Program Memoranda.